Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICARE AT OAKMONT
PO BOX 67181
DALLAS TX 75267

Respondent Name

FIDELITY & GUARANTY INSURANCE

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2257-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was originally processed under the physician fee schedule. We are an ASC. Several attempts have been made to collect additional monies due. Resulting only in 0 EOB's stating 'This bill is a reconsideration of a previously reviewed bill."

Amount in Dispute: $985.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated April 12, 2011: "Our bill review department has confirmed the bill for dos 08/23/10 submitted by Baylor Surgicare at Oakmont was processed under current fee schedule allowances for ASC providersup. [sic]" "No additional allowance is due at this time."

Response Submitted by: Gallagher Bassett, P.O. Box 23812, Tucson, AZ 85734

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2010	ASC Services for Code 64721-SG-RT	$985.29	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract and that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is

not provided in a timely manner to the division.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 22, 2010
   - W1-Workers compensation state fee schedule adjustment.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

   Explanation of benefits dated October 28, 2010
   - W1-Workers compensation state fee schedule adjustment.
   - BL-This bill is a reconsideration of a previously reviewed bill.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a recon is requested.
   - W1-This line was included in the reconsideration of this previously reviewed bill.

   Explanation of benefits dated December 9, 2010
   - W1-Workers compensation state fee schedule adjustment.
   - BL-This bill is a reconsideration of a previously reviewed bill.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a recon is requested.
   - W1-This line was included in the reconsideration of this previously reviewed bill.
   - BL-Additional allowance is not recommended as the claim was paid in accordance with state guidelines, usual customary policies, or the providers PPO contract.

   Explanation of benefits dated January 17, 2011
   - W1-Workers compensation state fee schedule adjustment.
   - BL-This bill is a reconsideration of a previously reviewed bill.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a recon is requested.
   - W1-This line was included in the reconsideration of this previously reviewed bill.
   - BL-Additional allowance is not recommended as the claim was paid in accordance with state guidelines, usual customary policies, or the providers PPO contract.

   Explanation of benefits dated February 24, 2011
   - W1-Workers compensation state fee schedule adjustment.
   - BL-This bill is a reconsideration of a previously reviewed bill.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a recon is requested.
   - W1-This line was included in the reconsideration of this previously reviewed bill.
   - BL-Additional allowance is not recommended as the claim was paid in accordance with state guidelines, usual customary policies, or the providers PPO contract.

   Explanation of benefits – undated.
   - BL-To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a recon is requested.
   - 18-Duplicate claim/service.

Issues

1. Does the submitted documentation support a contract exist between the parties for the disputed services?
2. Did the requestor support position that additional reimbursement is due for ASC services for code 26746-F2? Is the requestor entitled to reimbursement?
3. Did the requestor support position that additional reimbursement is due for ASC services for code 26735-F2? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with “state guidelines, usual customary policies, or the providers PPO contract”. The “PPO REDUCTION” amount on the submitted explanation of benefits denotes a “0.00” discount. The Division finds that documentation does not support that the services were discounted due to a contract; therefore reimbursement for the disputed services will be reviewed in accordance with 28 Texas Administrative Code §134.402.
2. 28 Texas Administrative Code §134.402(d) states “ For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment

policies in effect on the date a service is provided with any additions or exceptions specified in this section."

28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

3. HCPCS code 64721 is defined as "Neuroplasty and/or transposition; median nerve at carpal tunnel."

   28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for HCPCS code 64721 is:
   The Medicare ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures.
   The ASC fully implemented relative payment weight for CY 2010 = 17.4807.
   This number is multiplied by the 2010 Medicare ASC conversion factor of 17.4807 X $41.873 = $731.96.
   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $365.98 ($731.96/2).

   This number X City Conversion Factor/CMS Wage Index for Fort Worth, Texas is $365.98 X 0.9499 = $347.64.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $365.98 + $347.64 = $713.62.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $713.62 X 235% = $1,677.00.

4. The MAR for HCPCS code 64721 is $1,677.00. The insurance carrier paid $1,695.10. As a result, the amount recommended for additional reimbursement is $0.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division concludes that the requestor has not supported its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/9/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.